State of California Department of Consumer Affairs

PHYSICAL THERAPY BOARD OF CALIFORNIA
Consumer Protection Services Program
1418 HOWE AVENUE, SUITE 16, SACRAMENTO, CA 95825-3204
TELEPHONE (916) 561-8200 FAX (916) 263-2560 TOLL FREE 1-800-832-2251
INTERNET http://www.ptb.ca.gov
EMAIL cps@dca.ca.gov

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____

Medical Record No. or SSN _____ Date of Birth: _____

Date of Death: _____
(If Applicable)

I, the undersigned, hereby authorize:
(Please list one Physical Therapist, Physical Therapist Assistant, or Facility per box)

Physical Therapist/ Assistant: _____
(Last Name) (First Name) (M.I.)

Address: _____

Phone Number(s): _____ Treatment Date(s): _____

Physical Therapist/ Assistant: _____
(Last Name) (First Name) (M.I.)

Address: _____

Phone Number(s): _____ Treatment Date(s): _____

Physical Therapist/ Assistant: _____
(Last Name) (First Name) (M.I.)

Address: _____

Phone Number(s): _____ Treatment Date(s): _____

to provide records in the course of my treatment, including physical therapy, medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the **PHYSICAL THERAPY BOARD OF CALIFORNIA, CONSUMER PROTECTION SERVICES**, a healthcare oversight agency. This disclosure of records, authorized herein, is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Physical Therapy Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Physical Therapy Board of California, 1418 Howe Avenue, Suite 16, Sacramento, CA 95825. My written revocation will be effective upon receipt by the Physical Therapy Board of California but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____ _____

Patient Date

Or:

_____ _____

Legal Representative Relationship Date

NOTE TO THE PROVIDER: This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.

(Rev. 9/05)